MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Distribution: Laboratory 01-03
Practitioner 01-02
Family Planning 01-02

Issued: April 1, 2001

Subject: Uniform Billing Changes
New Laboratory Policy

Effective: August 1, 2001

Programs Affected: Medicaid, CSHCS, State Medical Program

Effective for services rendered on or after August 1, 2001, the Department of Community Health (DCH) is implementing changes in coverage and reimbursement policies, and claim submission requirements for Laboratories. These changes will help align DCH requirements with those of other major health insurers and are a step toward HIPAA (Health Insurance Portability and Accountability Act of 1996) compliance.

This bulletin contains information about specific changes being implemented for Laboratories. You should also refer to Medicaid Bulletin MSA 01-01 (revised Chapter IV) issued January 1, 2001, for additional information regarding claims completion requirements. Copies of all draft and final policy bulletins, the electronic claim transaction set, and other information related to changes being made are available on the DCH website at www.mdch.state.mi.us, click on Medical Services Administration, Information for Medicaid Providers.

The following changes will be implemented August 1, 2001:

- Effective August 1, 2001, laboratories must bill utilizing the National Electronic Data Interchange Transaction Set Health Care Claim: Professional 837 (ASC X12N 837, version 3051) for electronic claims or the HCFA 1500 paper claim form.

- Effective for dates of service on and after August 1, 2001, providers must provide their Clinical Laboratory Improvements Act (CLIA) number in Box 23 on the HCFA 1500 paper claim form or Loop 2400 REF02 in the electronic format. If no CLIA number is entered on the claim form, the claim will be rejected.

- Providers' CLIA certificate will determine the level of lab tests that can be performed in the office setting, family planning clinic or independent lab.

- The list of physician office laboratory procedures will be discontinued. Providers will be limited to the lab tests allowed under their CLIA certificate. For example, providers who only have the Certificate of Waiver Testing will be limited to those tests. The categorization of the tests under CLIA and the lists of tests within those categories can be found at the CLIA home page at www.hcfa.gov/medicaid/clia/cliahome.htm.

- The DCH has a laboratory daily reimbursement limit per beneficiary for independent laboratories and physician offices. The independent laboratory daily dollar limit is $125 and the daily dollar limit for physician offices is $50 per beneficiary. Family planning clinics will also be subject to the daily dollar limit that is in effect for physician offices. Additional information regarding the laboratory daily dollar limit is contained in Chapter III of your provider manual.

- There are selected laboratory services that are exempt from the daily dollar limit.

    - 80500
    - 80502
    - 85095-85102
    - 87901
    - 87903
    - 87904
    - 88104-88108
    - 88140-88199
    - 88230-88299
    - 88348

- Independent labs must continue to report the referring Medicaid provider ID number on the claim. Claims without the referring ID number will be rejected.

- Providers will now have to use modifiers, where appropriate, when billing for laboratory procedures. Modifiers to be used are:

    QW CLIA Waived Test:

    26 Professional component only

    TC Technical component modifier

    90 Reference lab (PT 16 only)

    91 Repeat Clinical Diagnostic Laboratory Test

- Place of service must be reported using the 2-digit HCPCS place of service codes. Independent laboratories, physician office labs and family planning clinics are limited to ambulatory settings. If a facility setting is reported, the claim will reject. See the revised Chapter IV, dated August 1, 2001, of your provider manual for additional information on place of service.

- The type of service will no longer be reported on the claim.

- When billing lab panels, providers must refer to the CPT manual for the lab panels and the tests that are defined as components of that panel.

The instructions for billing on the HCFA 1500 claim form or the electronic format are included in the revised Chapter IV, dated August 1, 2001, of your provider manual.

Manual Maintenance

Retain this bulletin for future reference. A revised Chapter III will be forthcoming.

Questions

Any questions regarding this bulletin should be directed to: Provider Inquiry, Medical Services Administration, P.O. Box 30479, Lansing, MI 48909-7979, or e-mail at ProgramSupport@state.mi.us. Providers may phone toll-free 1-800-292-2550.

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